# State of Alaska Division of Retirement and Benefits

## *Select Benefits* Enrollment Guide

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IMPORTANT:

This guide contains only a summary of benefits. The AlaskaCare Employee Health Plan document will prevail whenever there is a difference in interpretation between this guide and the Plan document.

Depending on the coverage you had last year, you may be required to re-enroll due to changes in coverage or the requirements of the particular program. The guidelines are:

| Type Of Coverage | Action Required |
|---|---|
| AlaskaCare (medical, dental, vision) | If elected in 2017 and you make no changes, the same coverage will rollover to 2018 based on family demographic (Employee Only or Employee and Family) with the exception of Opt-Out elections. To continue to opt-out of coverage you must re-enroll in the Opt-Out election or your coverage will be defaulted to the Economy plan. |
| AlaskaCare Opt-Out options | Plan **requires re-enrollment** every benefit year. Failure to reenroll will result in your coverage under the default Economy Medical and/or Dental plans for you and your family (if applicable). |
| Short-Term Disability | If elected in 2017 coverage will rollover to 2018 |
| Long-Term Disability | If elected in 2017 coverage will rollover to 2018 |
| Life Insurance | If elected in 2017 coverage will rollover to 2018 |
| Health Flexible Spending Account Coverage | Plan **requires re-enrollment** every benefit year |

| | |
|---|---|
| Accidental Death & Dismemberment | If elected in 2017 coverage will rollover to 2018 |
| Critical Care | If elected in 2017 coverage will rollover to 2018 |
| | |

## How to Enroll

The enrollment process will be completed online and personalized information will not be sent to members. **Everything you need to make decisions about your benefits and to change your enrollment selection is available at *Alaska.gov/drb/OpenEnrollment.***

Once you are ready to enroll, the Web site provides instructions to:

- Log in to your myAlaska account:
  - Go to myRnB.alaska.gov. This is the myRnB portal.
  - On the right side of the page, choose "Login using myAlaska." You will be directed to the myAlaska login page, where you will login using your myAlaska ID and password. This is the same ID and password you use to register for your PFD. After you login to myAlaska, you will be redirected back to myRnB.

- **Please take a moment to review the dependents listed in the Online Enrollment system, and add or update the information as appropriate.** Under the individual shared responsibility provision of the Affordable Care Act (ACA), individuals must indicate their enrolled dependents, as well as themselves, have had a full year of qualifying health care coverage (called minimum essential coverage), qualify for an exemption, or pay a penalty when filing their income taxes. By providing your dependent social security numbers, we can report proof of minimum essential health care coverage to help you avoid a tax penalty or the hassle of having to prove to the IRS that your dependents had coverage.

- View your current benefits (if applicable) and change your elections - with premiums automatically calculated for you by the enrollment system.

The benefits you are enrolled in on January 1, 2018, cannot be changed until the next benefit year unless you have a qualified status change. If you do not enroll by the November 22 deadline, your current health plan elections will remain in force, or default as described above, through the benefit year ending December 31, 2018. Participants in the Health Flexible Spending Account or Opt-Out medical or dental plans **do not** automatically re-enroll and must choose to enroll each benefit year.

If you experience technical difficulties while trying to enroll contact the Member Services Contact Center at (800) 821-2251 or in Juneau at (907) 465-4460 Monday through Thursday, 8:30 a.m. to 4 p.m. (Alaska Time); Friday, 8:30 a.m. to 3 p.m. (Alaska Time).

# Introduction

Select Benefits allows you to choose your benefit plans. Because you may have different needs than your coworkers and friends, you can create a personal benefit program from a range of benefits and levels of coverage. Best of all, you can spend your dollars for benefits that better meet your needs. Here's how it works:

- You consider the monthly cost of each option and decide which benefits to purchase.
- If you make selections that require a monthly employee contribution, that amount will be taken through pretax payroll deductions. This means deductions are withheld from your pay before federal income taxes are applied. The monthly employee contribution amount is divided in half and deducted from your paychecks in equal amounts throughout the benefit year.

# Coordination

Under the authority of 2 AAC 39.920, *Select Benefits* will only pay 30 percent of covered charges for your dependents if your spouse or children are covered by a State employee health trust and that coverage:

- has been waived,
- pays less than 70 percent of covered expenses, or
- has an individual out-of-pocket maximum, including deductible, of more than $3,500.

This applies to any dependent covered by *Select Benefits* as the secondary plan under the standard COB rules and where the trust plan would normally pay first if you hadn't reduced or waived coverage. When your spouse or the parent of any of your children selects coverage under a State employee health trust, they must ensure they are electing a plan that covers at least themselves and any dependents for which they have primary responsibility and that coverage provides full family coverage. Failure to do so will result in less coverage for your dependents in the coming year. For examples and more information, please see the Coordination of Benefits brochure on the Division's website.

## Waiver of Coverage (opt-out)

Effective January 1, 2018, if you are an AlaskaCare Employee Health Plan covered employee with other medical coverage, you may elect to opt-out, or waive, coverage for yourself and your family for one or more of the medical, dental, and vision plans offered through AlaskaCare. You may also elect employee-only coverage while opting-out of coverage for your family from one or more of the AlaskaCare benefits.

This change gives you the broadest choice of options to best suit your family's needs. But take caution when considering your elections. The option to opt-out of AlaskaCare medical coverage is only available if you or your family maintains coverage under another medical plan. **There are financial and tax consequences if you opt-out and do not have other medical coverage.** These restrictions do not apply to the dental or vision plans.

**The decision to opt-out is irrevocable for the benefit year (January 1 through December 31)!**

Before making a decision to opt-out of coverage you should check your other coverage plan. Some plans may charge an additional fee if you opt-out of AlaskaCare and this should be factored into your decision.

## Medical Plan

Your medical coverage helps you and your eligible dependents pay for hospital, surgical, and other medical expenses. You can choose from the two different *Select Benefits* medical options listed in the comparison chart below. Your dependents, if any, are automatically covered under the same option in *Select Benefits* medical plan unless you elect to waive their coverage. You'll see that the deductible, coinsurance, and out-of-pocket maximums are different for each option. To determine which plan is right for you, think about how much you can afford out of your own pocket to pay for medical expenses.

| | Standard Plan | Economy Plan | Consumer Choice |
|---|---|---|---|
| **Monthly Employee Contribution** | | | |
| Employee Only | $115 | $30.00 | |
| Employee and Family | $315 | $75.00 | |
| **Deductibles** | | | |
| Annual individual **deductible** | $400 | $600 | $2,500 |
| Annual family **deductible** | $800 | $1,200 | $5,000 |
| **Coinsurance** | | | |

| | Standard Plan | Economy Plan | Consumer Choice |
|---|---|---|---|
| Most medical expenses<br>• $100 penalty if seek non-**emergency** care at emergency room of a **hospital** | 80% | 70% | 70% |
| Most medical expenses after **out-of-pocket limit** is satisfied | 100% | 100% | 100% |
| Medical expenses for your **spouse** or **dependent children** if they are eligible to be covered by a **State** employee health trust and that coverage (i) has been waived, (ii) pays less than 70% of the **covered expenses**, or (iii) has an individual out-of-pocket limit, including **deductible**, of more than $3,500. | 30% | 30% | 30% |
| **Facility** services with a **network provider** in other 49 states or preferred provider **facility** in Anchorage | 80% | 70% | 70% |
| **Facility** services with an out-of-**network provider** in other 49 states or non-preferred provider **facility** in Anchorage | 60% | 50% | 50% |
| Transplant services at a non-Institute of Excellence™ facility | 60% | 50% | 50% |
| Transplant services if an Institute of Excellence™ (IOE) facility is used | 80% | 70% | 70% |
| **Preventive services**<br>• In-network providers or when use of an out-of-network provider has been pre-certified. | 100% | 100% | 100% |
| **Preventive services**<br>• Out-of-network providers only | 80% | 70% | 70% |
| Hearing benefit | 80% | 80% | 80% |
| Inpatient **mental disorder** treatment with a **network provider** | 80% | 70% | 70% |
| Inpatient **mental disorder** treatment with an out-of-**network provider** | 60% | 50% | 50% |
| Inpatient **substance abuse** disorder treatment with a **network provider** | 80% | 70% | 70% |
| Inpatient **substance abuse** disorder treatment with an out-of-**network provider** | 60% | 50% | 50% |
| | **Out-of-Pocket Limit** | | |

| | Standard Plan | Economy Plan | Consumer Choice |
|---|---|---|---|
| Annual individual **out-of-pocket limit**<br>• The following expenses do not apply toward the **out-of-pocket limit**:<br>  • charges over the **recognized charge**;<br>  • non-**covered expenses**;<br>  • premiums;<br>  • **precertification** benefit reductions; and<br>• **Prescription drug** expenses | $1,850<br><br>$3,700 if use out-of-**network provider** for **facility** services outside Alaska, or non-preferred provider **facility** in Anchorage | $2,850<br><br>$5,700 if use out-of-**network provider** for **facility** services outside Alaska, or non-preferred provider **facility** in Anchorage | $5,500<br><br>$11,000 if use out-of-**network provider** for **facility** services outside Alaska, or non-preferred provider **facility** in Anchorage |
| Annual family **out-of-pocket limit**<br>• The following expenses do not apply toward the **out-of-pocket limit**:<br>  • charges over the **recognized charge**;<br>  • non-**covered expenses**;<br>  • premiums;<br>  • **precertification** benefit reductions; and<br>• **Prescription drug** expenses | $3,700<br><br>$7,400 if use out-of-**network provider** for **facility** services outside Alaska, or non-preferred provider **facility** in Anchorage | $5,700<br><br>$11,400 if use out-of-**network provider** for **facility** services outside Alaska, or non-preferred provider **facility** in Anchorage | $11,000<br><br>$1,000 if use out-of-**network provider** for **facility** services outside Alaska, or non-preferred provider **facility** in Anchorage |
| **Benefit Maximum** | | | |
| Individual limit on auditory benefits<br>• Maximum applies to a rolling 36 month period<br>Hearing exams limited to one per rolling 24 month period. | $3,000 | | |
| • Limit on travel for transplant services | $10,000 per **transplant occurrence** | | |
| **Visit Limit** | | | |
| Spinal manipulations including medical massage therapy when done in conjunction with spinal manipulations | 20 annual visit limit | | |
| Hearing Exams | One per rolling 24 month period | | |
| Home Health Care | 120 visits per benefit year 4 hours = 1 visit | | |
| Outpatient Hospice Expenses | Up to 8 hours per day | | |

| | Standard Plan | Economy Plan | Consumer Choice |
|---|---|---|---|
| Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits | No more than 2 therapy visits in a 24-hour period; 1 hour (four modalities) = 1 visit | | |
| Employee assistance program | 8 visits per problem per benefit year | | |
| **Benefit Year Limits** | | | |
| **Travel Benefits** | | | |
| Therapeutic Treatments | One visit & one follow-up visit | | |
| • Prenatal/Postnatal Maternity Care | One visit | | |
| • Maternity Delivery | One visit | | |
| • Presurgical, Postsurgical or second surgical opinion | One visit | | |
| • Surgical Procedure | One visit | | |
| • Allergic Condition | One visit per benefit year for each allergic condition | | |
| **Travel Limitations** | | | |
| Travel per diem without overnight lodging. | $51/day | | |
| Travel per diem with overnight lodging. | $89/night | | |
| Companion Expenses, if permitted under the **plan** | $31/night | | |
| Travel benefits without precertification | No benefits will be paid | | |
| Overnight lodging for transplant services, in lieu of other travel per diems. See section 3.5.23, Transplant Services, for other applicable criteria. | $50 per person/night, up to $100/night | | |

## Prescription Drugs

Prescription drugs are the fastest growing cost in most health plans, including ours. Higher claim costs from prescription drugs, as with any other expense, means higher premium payments to all participants in the plan. There are several ways to save on prescription drug costs including purchasing a generic or lower cost brand name drug, using the mail order pharmacy for maintenance drugs, or both.

The mail order pharmacy is simple to use for maintenance drugs. You need a prescription from your doctor which allows you to receive a 90-day supply at a time for up to one year. The mail order pharmacy form, available on *AlaskaCare.gov*, should be sent with the prescription and your copayment. The pharmacy will send your prescription by return mail along with information on calling to order refills.

| Prescription Tier | Coinsurance | Minimum Covered Person Payment | Maximum Covered Person Payment |
|---|---|---|---|
| **Retail 30 Day at Network Pharmacy** | | | |
| **Generic prescription drug** | 80% | $10 | $50 |
| **Preferred brand-name prescription drug** | 75% | $25 | $75 |
| **Non-preferred brand-name prescription drug** | 65% | $80 | $150 |

| Mail Order 31-90 Day at Network Pharmacy | |
|---|---|
| **Prescription Tier** | **Copayment** |
| **Generic prescription drug** | $20 |
| **Preferred brand-name prescription drug** | $50 |
| **Non-preferred brand-name prescription drug** | $100 |
| **Out-of-Network Pharmacy** | |
| **Coinsurance for all prescription drugs** | 60% |
| **Out-of-Pocket Limit** | |
| **Annual individual out-of-pocket limit** | $1,000 |
| **Annual family out-of-pocket limit** | $2,000 |

## Dental Plan

You are required to choose a dental plan unless you are a part time employee for whom coverage is optional. When making your choice, be sure to consider any other dental coverage available such as from a spouse's plan.

| | Standard Plan | Economy Plan |
|---|---|---|
| **Monthly Employee Contribution** | | |
| Employee Only | $34.00 | $0.00 |
| Employee and Family | $93.00 | $0.00 |
| **Deductible** | | |
| Annual individual **deductible** | $25 (waived for class I services) | $25 |
| Annual family **deductible** | $75 (waived for class I services) | $75 |
| **Coinsurance** | | |
| Class I (preventive) services | 100% | 100% |
| Class II (restorative) services | 80% | 10% |
| Class III (prosthetic) services | 50% | 10% |
| Orthodontia | 50% | Not Covered |
| **Benefit Maximum** | | |
| Annual individual maximum | $1,500 | $500 |
| Orthodontia lifetime individual maximum<br>☐ This maximum is not included in the annual individual maximum | $1,000 | Not Covered |

# Vision Plan

Vision Plan decisions must remain in effect at least two consecutive benefit years. You may make changes to your Vision Plan level of coverage only after this two consecutive benefit year period. Your first opportunity to change your Vision level of coverage will be the first Open Enrollment period or qualified status change following your two consecutive benefit year mandatory wait period. You are *not* required to choose a vision plan. However, if have eligible dependents and chose to elect vision coverage, you must elect Employee and Family vision coverage.

The Managed Care Plan, administered through Vision Service Plan (VSP), requires that you use a participating provider in order to receive the highest level of benefits. Choose a VSP doctor online (see VSP.com) or by calling VSP prior to making your appointment. Make an appointment with the VSP doctor and tell the doctor you are a VSP member. Please refer to the VSP brochure on our website at for more details.

| Benefit | Description | Copay | Frequency |
|---|---|---|---|
| **Monthly Employee Contribution** | | | |
| Employee Only | $33.00 | | |
| Employee and Family | $12.00 | | |
| **Well Vision Exam** | | | |
| WellVision Exam | Focuses on your eyes and overall wellness | $10 | Every calendar year |
| **Prescription Glasses** | | | |
| Frame | $130 allowance for frames<br><br>20% off amount over your allowance<br><br>$70 allowance at Costco | $25 (Prescription Glasses Benefit) | Every other calendar year |
| Lenses | Single vision, lined bifocal, and lined trifocal<br><br>Polycarbonate lenses for dependent children | Included in prescription glasses | Every calendar year |
| Lens Options | Anti-reflective coating – covered in full<br>Polycarbonate lenses – covered in full<br>Progressive lenses – covered in full<br>Scratch-resistant coating – covered in full<br>Average 35-40% off other lens options | $0<br>$0<br>$0<br>$0 | Every calendar year |
| **Contacts** | | | |
| Contacts (instead of glasses) | $130 allowance for contacts; copay does not apply<br><br>Contact liens exam (fitting & evaluation) | Up to $60 | Every calendar year |
| **Diabetic Care** | | | |
| Diabetic Eyecare Plus Program | Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal Screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask you VSP doctor for details. | $20 | As needed |
| **Extra Savings and Discount** | | | |
| Glasses & Sunglasses | 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision exam. Or, get 20% off from any VSP doctor within 12 months of your last WellVision exam. | | |

# Basic & Select Life Insurance & Accidental Death & Dismemberment (AD&D)

Notice: In the event of a discrepancy between this guide and the certificate of insurance, the certificate will prevail.

*Select Benefits* lets you customize the amount of life insurance that is right for your situation.

**Basic Life/AD&D**

Under the Group Life Insurance Plan, the State automatically provides you with:

- ACOA, GGU, Confidential, Exempt/Partially Exempt, LTC, PSEA, and Supervisory: $10,000 lump sum, payable regardless of cause, and $5,000 additional if death is accidental.
- All others: $2,000 lump sum, payable regardless of cause, and $5,000 additional if death is accidental.

If you have eligible dependents, your spouse and each dependent child are insured for up to $1,000 under the Group Life Insurance, Basic Life Plan.

Travel Accident

- $75,000 is payable if you are a MEBA member, and your death is accidental during travel status.
- $100,000 is payable if death is accidental during travel status.
- $200,000 ACOA, GGU, Confidential, Exempt/Partially Exempt, PSEA, and Supervisory only.

**Select Life/AD&D**

The amount available is equal to your annual income rounded to the next highest $1,000, depending on your bargaining unit. The maximum amount is $100,000 for Supervisory Union (SU), Confidential (KK), General Government (GC, GG, CP, GY, GZ), Public Safety (AA & AP), Partially Exempt and Exempt (XA, XE, XJ), and Boards and Commissions. The maximum amount for all other bargaining units is $60,000.

If you die from any cause, Select Life pays your beneficiary the full amount of your insurance. If you die from an accident, your Select AD&D pays your beneficiary an additional benefit equal to the value of your Select Life benefit.

| Select Life/AD&D Premiums | |
|---|---|
| **Age** | **Premium Per $1,000** |
| Under 30 | $0.05 |
| 30 - 39 | $0.06 |
| 40 - 44 | $0.10 |
| 45 - 49 | $0.15 |
| 50 - 54 | $0.23 |
| 55 - 59 | $0.36 |
| 60 - 64 | $0.51 |
| 65 - 69 | $0.74 |
| 70 - 74 | $1.63 |
| 75 - 79 | $2.06 |
| 80 - 84 | $2.06 |
| 85 & over | $2.06 |

## Notice: Voluntary Supplemental Benefits (VSB) Eligibility

Effective January 1, 2018, members of Labor, Trades, and Crafts (LTC), the Teachers' Retirement System (TRS), on-call employees, temporary legislative employees, employees of the National Guard (including Emergency Guard), short-term non-permanent employees, student interns, leased employees, and emergency employees hired for natural disasters, including emergency firefighters, are excluded from enrolling in Voluntary Supplemental Benefits (VSB). These plans include:

- Supplemental Life
- Supplemental Accidental Death and Dismemberment (AD&D)
- Critical Illness
- Short-Term Disability (STD)
- Long-Term Disability (LTD)

Temporary Legislative Employee is defined as, "an employee that is not on contract, and works less than 10 hours a week." Contract employees working less than 10 hours a week are eligible to enroll in VSB.

**Notice:** In the event of any discrepancy between this guide and the certificates of insurance for any Voluntary Supplemental Benefits (VSB), the certificate will prevail.

# Voluntary Supplemental Life

*Supplemental Life* is a different policy than Select Life/AD&D. You may choose from one of the following Life Insurance coverage levels offered through *Select Benefits*:

- No coverage
- $10,000
- $50,000
- $100,000
- $200,000*
- $300,000*

**When electing $200,000 or $300,000 you must submit a Statement of Health (SOH)*

SOH Information:

- ✓ Required for life volumes over $100,000 as an industry standard
- ✓ Establishes proof of good health
- ✓ Used to protect an employer's group insurance program from adverse risk
- ✓ Employees electing $200,000 or $300,000 in coverage who are denied will default to $100,000 for the benefit year
- ✓ Employees with questions regarding the information asked for on the EOI form must contact UNUM through December 31, 2016, and MetLife after January 1, 2016.

Guideline: When selecting coverage levels keep in mind the following rule:

- If you wish to elect Accidental Death and Dismemberment (AD&D) you must select at least $10,000 of Supplemental Life Insurance.

To determine your monthly life insurance premium, find your age as of January 1, 2018, the amount of insurance elected, and the corresponding premium on the following chart:

| Age | Rate Per $1,000 - per month |
|---|---|
| Under 30 | $0.03 |
| 30 – 39 | $0.04 |
| 40 – 44 | $0.08 |
| 45 – 49 | $0.12 |
| 50 – 54 | $0.19 |
| 55 – 59 | $0.28 |
| 60 – 64 | $0.40 |
| 65 – 69 | $0.63 |
| 70 – 74 | $1.29 |
| 75 – 79 | $2.06 |
| 80 – 84 | $2.06 |
| 85 & over | $2.06 |

## Supplemental Voluntary Accidental Death and Dismemberment (AD&D)

If you die because of an accident, your beneficiary will be paid by your Life Insurance and your AD&D Insurance. It also pays if you suffer certain injuries as the result of an accident, such as the loss of a limb or your eyesight. You may also select coverage for your family members. **To elect AD&D you must elect some level of Supplemental Insurance ($10,000, $50,000, $100,000, $200,000, or $300,000)**. When purchasing AD&D coverage, you have a choice of coverage levels:

- **Employee only**
  The full benefit amount for employee only coverage is $100,000.

- **Employee and family**
  The benefit amounts that are paid to you or your beneficiaries are based on the composition of your family at the time of the loss. The amount of the benefit is also based on the severity of your loss.

| 2017 Supplemental AD&D Rates | |
|---|---|
| | **Rate Per Month** |
| **Employee** | **$1.80** |
| **Employee and Family** | **$2.70** |

| Employee, Spouse, and Dependent Children | |
|---|---|
| Employee | $100,000 |
| Spouse | $40,000 |
| Each Child | $5,000 |
| **Employee and Spouse** | |
| Employee | $100,000 |
| Spouse | $50,000 |
| **Employee and Dependent Children** | |
| Employee | $100,000 |
| Each child | $10,000 |

| Type of Permanent Loss | Percentage of AD&D Coverage Paid |
|---|---|
| Life | 100% |
| Both eyes, feet, hands, or any combination thereof | 100% |
| One eye, one foot, or one hand | 50% |
| Thumb and index finger of the same hand | 25% |

## Critical Illness

The State of Alaska is pleased to offer you an opportunity to enroll in the Critical Illness Supplemental Insurance plan that can pay a lump sum upon certain diagnoses. Diagnoses include cancer, heart attack, major organ transplant, kidney failure, Alzheimer's disease, and other illnesses.

MetLife Critical Illness Insurance can complement existing medical coverage and help fill financial gaps caused by out-of-pocket expenses such as mortgage payments, college tuition, hiring household help, or treatment not covered by your medical plan.

Critical Illness Insurance provides several features that could be valuable to you, including:

- Portability which gives you the ability to keep your existing coverage if your employment status changes;
- No coordination with other insurance benefits;
- A lump-sum benefit that you can use as you feel necessary.
- Benefits are paid regardless of what is covered by medical insurance.

You can elect one of 2 levels of coverage, $15,000 or $30,000.

| Age | Options | | | | Rate Basis - Per Month (multiple by $15,000 or $30,000) |
|---|---|---|---|---|---|
| | Employee Only | Employee + Spouse | Employee + Children | Employee + Spouse/Children | |
| <25 | $0.190 | $0.33 | $0.36 | $0.50 | Per $1,000 |
| 25–29 | $0.210 | $0.35 | $0.37 | $0.52 | Per $1,000 |
| 30–34 | $0.290 | $0.48 | $0.45 | $0.64 | Per $1,000 |
| 35–39 | $0.410 | $0.67 | $0.58 | $0.84 | Per $1,000 |
| 40–44 | $0.630 | $1.00 | $0.79 | $1.17 | Per $1,000 |
| 45–49 | $0.950 | $1.50 | $1.12 | $1.66 | Per $1,000 |
| 50–54 | $1.390 | $2.17 | $1.55 | $2.33 | Per $1,000 |
| 55–59 | $1.950 | $3.05 | $2.12 | $3.21 | Per $1,000 |
| 60–64 | $2.820 | $4.40 | $2.99 | $4.57 | Per $1,000 |
| 65–69 | $4.270 | $6.65 | $4.44 | $6.81 | Per $1,000 |
| 70+ | $6.490 | $10.04 | $6.66 | $10.21 | Per $1,000 |

# Supplemental Voluntary Disability Benefits

The State recognizes that one of the most important assets you have is your ability to earn a living. Short and Long-Term Disability Insurance can provide you with income if an illness or injury keeps you from working.

Benefits are payable only if you are unable to work in your own occupation, and are under the care of a physician. After a two year period you must be permanently disabled, defined as unable to work in any gainful occupation.

**Short-Term Disability**
Short-Term Disability (STD) provides you continuing income if you become injured or disabled and are unable to work. Benefit payments begin after 30 days of disability and after all paid leave is exhausted. You receive benefits for up to 180 days from the date of your disability.

**Long-Term Disability**
If you remain totally disabled after 180 days, Long-Term Disability (LTD) coverage pays you a continuing monthly benefit. The length of time your benefit is paid depends on how old you are when you become disabled.

- ✓ The minimum monthly Long-Term Disability benefit payable after all offsets is $100.
- ✓ The maximum monthly Long-Term Disability benefit payable is $8,000.

**Options for Short-Term Disability**
- Plan A – Pays 60% of your salary or a maximum of $577 per week for a period of 5 months
- Premium is $2.04 monthly
- No coverage

**Options for Long-Term Disability**
- Plan B – 50% of base monthly pay
- Plan C – 70& of base monthly pay
- No coverage

| | Plan B - 50% Plan | Plan C - 70% Plan |
|---|---|---|
| Age | Monthly Rate Per $100 of covered payroll | Monthly Rate Per $100 of covered payroll |
| Under 25 | $0.28 | $0.63 |
| 25-29 | $0.29 | $0.64 |
| 30-34 | $0.29 | $0.65 |
| 35-39 | $0.30 | $0.66 |
| 40-44 | $0.31 | $0.70 |
| 45-49 | $0.34 | $0.75 |
| 50-54 | $0.37 | $0.82 |
| 55-59 | $0.41 | $0.89 |
| 60-64 | $0.42 | $0.91 |
| 65-69 | $0.44 | $0.94 |
| 70 & over | $0.54 | $1.13 |

# Health Flexible Spending Account

With the *Select Benefits* Health Flexible Spending Account (HFSA)
, you can set aside money to pay for certain health care expenses on a tax-free basis.

**Here's It Works**
Each benefit year, you decide the amount you want to contribute, up to the limit, on a pretax basis. During the benefit year, you file claims and are reimbursed with tax-free dollars from the account. You benefit from reduced taxes, because you don't pay taxes on the dollars you contribute to your account.

**Some Important Rules**
The government imposes certain restrictions on HFSA plans to give you these pre-tax advantages.

- You may enroll in your HFSA within 30 days of your date of hire, at open enrollment, or when you experience a qualified status change. **You must elect these benefits each open enrollment period, they do not automatically continue from one benefit year to the next.**

- Amounts are held in a separate HFSA account.

- Health Flexible Spending Accounts will now allow for a maximum $500 carry-over of unused funds from one benefit year to the next. This amount will be in addition to any new benefit year amount you select as deductions in your pay.

- Our benefit year runs from January 1 to December 31. With the exception of the $500 carry over in the HFSA plan, services must be received prior to the end of the benefit year, December 31. You have a 90 day grace period (until March 31) to file all unpaid claims for the prior benefit year.

- Services for eligible expenses must be received while you are covered by the plan—coverage stops during periods of leave without pay and at termination. Under HFSA, coverage also stops when you move to a bargaining unit which doesn't participate in the *Select Benefits* health plan, AlaskaCare. With the exception of the $500 carry over in the HFSA plan, services must be received prior to the end of the benefit year, December 31. Claims for the benefit year must be filed within 90 days of the end of the benefit year.

**How does it work?**
The Health Flexible Spending Account (HFSA) lets you pay for health care expenses not covered by your insurance. You choose how much to contribute to the account. The minimum contribution is $20 per month, the maximum is $216 per month.

**What Are Eligible Health Care Expenses?**
You can use the money you contribute to the account for the following health care expenses:

- Deductibles and copayments
- Amounts over reimbursed expenses
- Orthodontia
- Vision care (including eyeglasses and contact lenses)
- Hearing aids and exams
- Medicine and drugs prescribed by a physician

For a detailed listing of eligible expenses, refer to Internal Revenue Service (IRS) Publication 502, available from your local IRS office or their website at *www.irs.gov*.

**Claims Submission**

Claims to the HFSA may be submitted in one of two ways. If you enroll, you must select how you want your claims to be handled.

- *Streamlined claims submission*—With this option, health claims are sent to the claims administrator office by you or your provider as normal. Once your claim has been processed, any amounts that are unpaid by the health plan are then electronically transferred to the HFSA administrator. **You cannot elect this option if you or any of your eligible dependents have any other health coverage.** This includes a second State of Alaska plan (such as coverage through your spouse) or any other health insurance plan.

- *Direct claims submission*—With this option, you submit your claims to the HFSA administrator *after* receiving your explanation of benefits (EOB) from your group health plan(s). If you or any of your eligible dependents have more than one health plan, you must submit the claim with copies of the EOBs from all plans. **This is the only option available if you or any of your eligible dependents have more than one health plan.**

Under either option, the HFSA administrator will process the claim, sending an explanation of the payment and check directly to you.

## IMPORTANT:

The benefits you are enrolled in on January 1, 2017, cannot be changed until the next benefit year unless you have a qualified status change. If you do not enroll by the November 23 deadline, your current health plan elections will remain in force, or default as described above, through the benefit year ending December 31, 2017. Participants in the Health Flexible Spending Account **do not** automatically re-enroll and must choose to enroll each benefit year.

## Have additional questions?

Please consider attending one of our seminars in-person or via teleconference. Seminar schedules are available at ***Alaska.gov/drb/Seminars***. Recorded seminars can be viewed on the Division Web site as well.

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